MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06771

CERTIFICATE OF DEATH

06759

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: KENT
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERTOWN
c. LENGTH OF STAY IN 1b: SIX DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KENT AND QUEEN ANNE'S HOSPITAL, INC.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERTOWN (15 Yrs.)
d. STREET ADDRESS: 103 NORTH MILL STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAY Middle FRED Last ALLEGER

4. DATE OF DEATH: Month MAY Day 12 Year 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/15/00

9. AGE (In years last birthday): 66 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CUSTODIAN

10b. KIND OF BUSINESS OR INDUSTRY: CHRIST METHODIST CHURCH

11. BIRTHPLACE (County & State, or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? US.

13. FATHER'S NAME: EUGENE ALLEGER

14. MOTHER'S MAIDEN NAME: MALVINA CUSTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 166-07-2465

17. INFORMANT: HOSPITAL RECORDS Address: CHESTERTOWN, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): PLEURESY — Few Weeks
DUE TO (c): CARCINOMA OF LUNG — Few Months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from MAY 6, 1967, to MAY 12, 1967, that (I) (we) last saw the deceased alive on MAY 12 1967, and that death occurred at 9:40 A.M., from causes and on the date stated above.

22a. SIGNATURE: Jorge A. Oteiza M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-12-67

22c. PHYSICIAN'S NAME (Type): DR. J.A. OTEIZA

22d. ADDRESS: CHESTERTOWN, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/15/67

23c. NAME OF CEMETERY OR CREMATORY: Chester Cem.

23d. LOCATION (City or Town) (County) (State): Chestertown, Md.

24. FUNERAL DIRECTOR: J. Willis Wells ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE: MAY 16 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06772 06760

1. PLACE OF DEATH
a. COUNTY: Kent County, Maryland — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): R.F.D. Chestertown, Md.
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): At the home of Mrs. Lena Williams

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R.F.D. Chestertown, Maryland
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Annie Middle: Last: Bell

4. DATE OF DEATH: Month: 5 Day: 5 Year: 1967

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1/5/1880

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: Various

11. BIRTHPLACE (County & State, or foreign country): Kent County, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Robert Blake

14. MOTHER'S MAIDEN NAME: Sally Hopkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 212-40-9167

17. INFORMANT Address: Mrs. Lena Williams Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): A.S.C.V.D
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 3-30, 1967, to 4-28, 1967, that (I) (we) last saw the deceased alive on 4-28 1967, and that death occurred at [illegible] M, from the causes and on the date stated above.

22a. SIGNATURE: Harry Paul Ross M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-6-67

22c. PHYSICIAN'S NAME (Type): Harry Paul Ross M.D.

22d. ADDRESS: Chestertown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/8/1967

23c. NAME OF CEMETERY OR CREMATORY: Janes Cemetery

23d. LOCATION (City, town or county) (State): R.F.D. Chestertown, Md.

24. FUNERAL DIRECTOR: Emmett Wolfe

ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE: MAY 9 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06773 Reg. Dist. No. 06761

1. PLACE OF DEATH
a. COUNTY: Kent County, Maryland MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R. Chestertown, Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: In Doctor's Office

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Maryland
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R.F.D.#1 Chestertown, Maryland
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mattie Middle Last Benjamin
4. DATE OF DEATH: Month 5 Day 10 Year 19 67
5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10/9/ 1890
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor
10b. KIND OF BUSINESS OR INDUSTRY: Various
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Lee Dent
14. MOTHER'S MAIDEN NAME: Mary E.Holley
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212-14-4013
17. INFORMANT: Address: Mr.Linwood Lively Sr. Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral vascular hemorrhage.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH: 1½ hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): History of previous attack 1 year ago.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5/9/67, 1967, to 5/10, 1967, that I last saw the deceased alive on 5/10, 1967, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas J Solon M.D.
ADDRESS (Street, city or town, state): 500 Kent Street
DATE SIGNED: 5/10/67
PHYSICIAN'S NAME (Type): Thomas J. Solon, M. D.
Chestertown, Md. 21620

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/14/1967
22c. NAME OF CEMETERY OR CREMATORY: Joshua Chaple Cem.
22d. LOCATION (City, town, or county) (State): R.F.D. Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Lennette Colby
ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR DATE: MAY 16 1967
24b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be signed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06774 — 06762

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Betterton
c. LENGTH OF STAY IN 1b: lifetime
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Betterton
d. STREET ADDRESS: 14-1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Nelson — Middle Leroy — Last BOONE

4. DATE OF DEATH: Month May — Day 15, — Year 19 67

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 31, 1905

9. AGE (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Heavy Equiptment Operator (Retired)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Kent Co. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John E. Boone

14. MOTHER'S MAIDEN NAME: Mattie Leigh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 220 12 2435

17. INFORMANT — Address: Mrs. Hattie Wyble - Betterton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: 10 min.
416 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Probable pulmonary infarction — 10 min.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Mitral insufficiency.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 21, 1956 to May 15, 1967, that (I) (we) last saw the deceased alive on 5/15/67 19, and that death occurred at 9:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Thomas J. Solon — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/16/67

22c. PHYSICIAN'S NAME (Type): Thomas J. Solon

22d. ADDRESS: Chestertown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/18/67

23c. NAME OF CEMETERY OR CREMATORY: Still Pond Cem

23d. LOCATION (City, town or county) (State): Still Pond, Md.

24. FUNERAL DIRECTOR: J. Willis Wells — ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR — DATE: MAY 18 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06775 06763

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millington
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nora; Middle:; Last: Bowers

4. DATE OF DEATH: Month: May; Day: 20; Year: 1967

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 1, 1907

9. AGE (In years last birthday): 60 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alex Bowers

14. MOTHER'S MAIDEN NAME: Amelia Stanley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 218-24-7269HA

17. INFORMANT: James Wells Address: Millington, Maryland. 21651

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardio Vascular insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 2 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Rheumatic heart disease
DUE TO (c): Chronic Rheumatic fever.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11-5-64, 19__, to 5-19-, 1967, that (I) (we) last saw the deceased alive on 5-19-1967, and that death occurred at 1A M, from the causes and on the date stated above.

22a. SIGNATURE: Rudolfs Eglitis M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-22-67

22c. PHYSICIAN'S NAME (Type): Rudolfs Eglitis, M.D.

22d. ADDRESS: Roonstall, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 24, 1967

23c. NAME OF CEMETERY OR CREMATORY: Davis Hill Cemetery

23d. LOCATION (City, town or county) (State): Galena, Maryland

24. FUNERAL DIRECTOR: Edward Fellows ADDRESS: Millington, Maryland

25a. REC'D BY REGISTRAR DATE: MAY 25 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR 415 (4) 20M 1/65

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06776 — 05764

1 PLACE OF DEATH — a COUNTY: Kent County — MARYLAND; b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Chestertown; c LENGTH OF STAY IN 1b:

2 USUAL RESIDENCE (Where deceased lived, If institution Residence before admission) — a STATE: Maryland; b COUNTY: Kent Co.; c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown

d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent Queen Anne's Hospital

d. STREET ADDRESS: Route #3

e IS RESIDENCE ON A FARM? YES ☒ NO ☐

3 NAME OF DECEASED (Type or print): First: Joseph; Middle: Wesley; Last: Brown

4 DATE OF DEATH: Month: May; Day: 12; Year: 1967

5 SEX	6 COLOR OR RACE	7 MARITAL STATUS	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS
M	N	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	4-4-1887	80 yrs	Months: — Days: —	Hours: — Min: —

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. farmer

10b KIND OF BUSINESS OR INDUSTRY: —

11 BIRTHPLACE (City & State or foreign country): Kent Co. Md.

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: William Alexander Brown

14 MOTHER'S MAIDEN NAME: Mary Anne Grace

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): —

16 SOCIAL SECURITY NO: X-S

17 INFORMANT — Address: Hospital records

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Stroke & Lt. hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: Hours

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): A.S.C.V.D

DUE TO

(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 5-2- , 1967, to 5-12 , 1967, that (I) (~~we~~) last saw the deceased alive on 5-12 1967, and that death occurred at 8:35 P.M. from causes and on the date stated above

22a SIGNATURE: Harry P Ross — M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b DATE SIGNED: 5-13-67

22c PHYSICIAN'S NAME (Type): L. Harry P. Ross

22d ADDRESS: Chestertown, Md. 21620

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/16/67

23c. NAME OF CEMETERY OR CREMATORY: Emmanuel Meth. Cem.

23d LOCATION (City or Town) (County) (State): Chestertown, Md.

24 FUNERAL DIRECTOR: Emmett Kelly — ADDRESS: Chestertown, Md.

25a RECD BY REGISTRAR — DATE: MAY 17 1967

25b REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

25777 — 06765

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Chestertown, Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Kent & Queen Anne Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall, Md.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Rosetta — Middle: — Last: Coxon

4. DATE OF DEATH: Month: May — Day: 5, — Year: 1967

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/3/1901

9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James F. Baker

14. MOTHER'S MAIDEN NAME: Susan Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 215 20 0198

17. INFORMANT: Henry J. Coxon — Address: Rock Hall, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CONGESTIVE HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 12 HRS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): HYPERTENSION — SEV. YEARS
DUE TO (c): OBESITY. — SEV. YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-12-, 1967, to 5-5, 1967, that (I) (we) last saw the deceased alive on 5-5- 1967, and that death occurred at 10:45 PM, from the causes and on the date stated above.

22a. SIGNATURE: Dr Stiga — M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-5-67

22c. PHYSICIAN'S NAME (Type): Jorge A. Otezla

22d. ADDRESS: Chestertown, Md. 21620

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/7/67

23c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel Cem

23d. LOCATION (City, town or county) (State): Rock Hall, Md.

24. FUNERAL DIRECTOR: J. Willis Wells

ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE: MAY 8 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06778 — 06766

1 PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 12 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Anne's Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Hiram — Middle: Jonas — Last: Crew

4. DATE OF DEATH: Month: 5 — Day: 24 — Year: '67

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 9/25/1884

9 AGE (In years last birthday): 82 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (County & State or foreign country): ChestertownMaryland

12 CITIZEN OF WHAT COUNTRY? US

13 FATHER'S NAME: William Crew

14 MOTHER'S MAIDEN NAME: Mollie Pierce

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16 SOCIAL SECURITY NO: 215-20-1103

17 INFORMANT: Hospital Records — Address: Chestertown, Md. 21620

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Arteriosclerotic Cardio-Vascular
DUE TO
(b):
(Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last)
DUE TO (c): Myocardial Infarction with Congestive Heart Failure

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. APR ? 1967

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm factory, street office bldg. etc)

20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5/12, 19 67, to 5/24, 19 67 that ( ) (we) last saw the deceased alive on 5/24 19 67, and that death occurred at 3:20 A.M. from causes and on the date stated above

22a. SIGNATURE: [signature]
M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: 5/27/67

22c PHYSICIAN'S NAME (Type): Dr. A. T. Keefe

22d. ADDRESS: Chestertown, Maryland 21620

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: May 26

23c NAME OF CEMETERY OR CREMATORY: Wesley Chapel

23d LOCATION (City or Town) (County) (State): Rock Hall, Maryland

24 FUNERAL DIRECTOR: Edgar L. Lane — ADDRESS: Church Hill, Md.

25a DEPUTY REGISTRAR DATE: MAY 29 1967

25b REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06773 — 06767

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Kent
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: short
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Kent & Queen Anne

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kennedyville
d. STREET ADDRESS: Kentmore Park
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Wellington Earl Middle: Duke Last: Sr.

4. DATE OF DEATH: Month: May Day: 24 Year: 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 29, 1904

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): R tired Electrician

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Yonkers. N.Y.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Francis Duke

14. MOTHER'S MAIDEN NAME: Jeanette Gould

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 179 01 1286

17. INFORMANT Address: Elfrieda D. Duke - Kennedyville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): with symptoms and history highly sug- — 1 hr.
DUE TO (c): gestive of a massive coronary infarct

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-24-67, 19__, to 5-24-67, 19__, that (I) (we) last saw the deceased alive on 5-24 19 67, and that death occurred at 9:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: A. C. Dick M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/24/67

22c. PHYSICIAN'S NAME (Type): A. C. Dick

22d. ADDRESS: Chestertown, Md. 21620

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/27/67

23c. NAME OF CEMETERY OR CREMATORY: Crumpton Cem.

23d. LOCATION (City, town or county) (State): Crumpton, Md.

24. FUNERAL DIRECTOR: J. Wills Wells

ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE: MAY 29 1967

25b. REGISTRAR'S SIGNATURE: [illegible] Judge

VR A15 (4) 20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06780 — 06758

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 529 High St.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
d. STREET ADDRESS: 529 High St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Olie — Middle: — Last: Ford

4. DATE OF DEATH: Month: May — Day: 24, — Year: 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 27, 1879

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Merritt Ford

14. MOTHER'S MAIDEN NAME: Hester Newnam

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 220 34 9954

17. INFORMANT: Bessie Ford — Address: Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Complications of old age — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August 10, 1965, to May 24, 1967, that (I) (we) last saw the deceased alive on 5-20 1967, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: A. C. Dick M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/24/67

22c. PHYSICIAN'S NAME (Type): A. C. Dick

22d. ADDRESS: Chestertown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/26/67

23c. NAME OF CEMETERY OR CREMATORY: Galena Cemetery

23d. LOCATION (City, town or county) (State): Galena, Maryland

24. FUNERAL DIRECTOR: J. Willis Wells — ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE: MAY 29 1967

25b. REGISTRAR'S SIGNATURE: J. Lowber Jones

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

96781 — 06769

1 PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limit write RURAL and give nearest town): Chestertown
LENGTH OF STAY IN:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Kent & Queen Anne Hospital (2hrs)

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limit write RURAL and give nearest town): Chestertown Lifetime
d. STREET ADDRESS: 103 Pine St.

3 NAME OF DECEASED (Type or print): First DAVID — Middle J. — Last FOWLER

4 DATE OF DEATH: Month May — Day 14 — Year 1967

5 SEX: male

6 COLOR OR RACE: white

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: April 29, 1949

9 AGE (Last birthday): 18 yrs.
If under 1 year: Months — Days
If under 24 hr.: Hours — M

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student & Radio announcer

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Cecil Co. Maryland

12 CITIZEN OF WHAT COUNTRY: USA

13 FATHER'S NAME: John Fowler

14 MOTHER'S MAIDEN NAME: Fay Chance

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) If yes give war or dates of service: no

16 SOCIAL SECURITY NO.: 220 52 0298

17 INFORMANT — Address: John Fowler - Chestertown, Md.

18 CAUSE OF DEATH (Enter only one cause per line for a), b) and c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fracture base of skull - severe
DUE TO: Auto accident. ~~Body thrown in field some distance from auto. Brought to hospital by bystanders. Course~~
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO: ~~was rapidly downhill.~~
(c)
INTERVAL BETWEEN ONSET AND DEATH: 2 3/4 Hrs

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19 WAS AUTOPSY PERFORMED? Yes ☐ No ☒

MEDICAL CERTIFICATION

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Hour 12:45 xx — Month/Day 5/14 — Year 67

20d INJURY OCCURRED While at work ☐ Not while at work ☒

20e PLACE OF INJURY (Home, factory, street, office bldg., etc.): highway

20f CITY, TOWN OR LOCATION: near Lynch Kent Md.

21 I certify that I took charge of the remains described above held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Robert W. Farr — Chestertown
EXAMINER'S NAME (Type): Robert W. Farr — Kent Co. Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street No. or R.F.D., City or County, State)

22 DATE SIGNED: 5/14/67

23a PLACE OF CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 5/16/67
23c NAME OF CEMETERY OR CREMATORY: St. Paul Cem.
23d CITY, TOWN OR COUNTY, STATE: near Chestertown, Md.

24 FUNERAL DIRECTOR: J. Willis Wells
ADDRESS: Chestertown, Md.

RECEIVED BY REGISTRAR (DATE): MAY 18 1967
REGISTRAR (SIGNATURE): Frances Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if circumstances necessary, please execute the certificate, writing the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 is to be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06782

CERTIFICATE OF DEATH

0640

1 PLACE OF DEATH
a COUNTY: Kent — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c LENGTH OF STAY IN 1b: 45 days
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Anne's Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Maryland
b COUNTY: Kent
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall
d STREET ADDRESS: None
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Florence — Middle: May — Last: Francis

4. DATE OF DEATH: Month: 5 — Day: 26 — Year: 19 67

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 9/18/1883
9 AGE (In years last birthday): 83 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of work life even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (County & State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? US

13 FATHER'S NAME: Walton Sutton
14. MOTHER'S MAIDEN NAME: Emma Wilson

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16 SOCIAL SECURITY NO: 220-16-9699
17 INFORMANT: Hospital Records — Address: Chestertown, Md. 21620

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Carcinomatosis due to
DUE TO (b) metastatic carcinoma from left breast — INTERVAL BETWEEN ONSET AND DEATH: 6 months
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 4/11, 19 67 to 5/26, 1967, that (I) (we) last saw the deceased alive on 5/26 19 67, and that death occurred at 3:25 A.M., from causes and on the date stated above

22a SIGNATURE: A. C. Dick M.D. — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 5-26-67
22c PHYSICIAN'S NAME (Type): Dr. A. C. Dick
22d. ADDRESS: Chestertown, Maryland 21620

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 5/29/67
23c NAME OF CEMETERY OR CREMATORY: St. Paul Cemetery
23d LOCATION (City or Town) (County) (State): Near - Chestertown, Md.

24 FUNERAL DIRECTOR: J. Willis Wells
ADDRESS: Chestertown, Md.
25a REC'D BY REGISTRAR DATE: MAY 31 1967
25b REGISTRAR'S SIGNATURE: [illegible] Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is anticipated please execute the certificate writing the word pending in pencil in Item 18. Give Pages 1 and 2 only to the funeral director who will be required to present it to the Chief Medical Examiner's Office along with form HM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: This certificate should be used as a burial transit permit File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

96783

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06771

PLACE OF DEATH
a. COUNTY: Kent
b. STATE: MARYLAND
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
LENGTH OF STAY IN THIS PLACE: 39 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Annes

USUAL RESIDENCE (Where deceased lived. If institution, give usual residence of person before admission.)
a. STATE: Delaware
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL): Smyrna
d. STREET ADDRESS
RESIDENCE ON A FARM: YES [ ] NO [X]

NAME OF DECEASED (Type or print): First CHARLES Middle GRAHAM Last
4. DATE OF DEATH: Month May Day 8 Year 19 67
SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Nov 7, 1917
9. AGE (In years last birthday): 49 yrs
IF UNDER 1 YEAR: Months / Days / Hours / Min

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor
10a. KIND OF BUSINESS OR INDUSTRY: Various
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Coleman Graham
14. MOTHER'S MAIDEN NAME: Stella Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO: Yes
17. INFORMANT: Hospital records, Chestertown, Md.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Hemoperitoneum
DUE TO
(b): Contusion of liver and spleen
DUE TO
(c): Multiple fractures of ribs, right
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH: 39 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I
AUTOPSY: YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Sustained in auto accident
TIME OF INJURY: Hour about 1 Date 5/7/67 19
WORK: Yes [ ] No [X]
highway
nr Sudlersville MA md.

21. I certify that I took charge of the remains described above held an Autopsy [X], Inspection [ ], Inquest [ ] and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Robert W. Farr MD
EXAMINER'S NAME (Type): Robert W. Farr
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town or county): Kent Co
22. DATE SIGNED: 5/9/67

23. METHOD OF DISPOSITION: Burial
DATE: 5/15/1967
NAME OF CEMETERY OR CREMATORY: Odd Fellow's Cem.
ADDRESS: Chestertown, Md.
PLACE OF DISPOSITION: Smyrna Del

24. FUNERAL DIRECTOR: Bennett Wallace
25a. RECEIVED BY REGISTRAR DATE: MAY 10 1967
25b. REGISTRAR SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

96784 — 06712

1. PLACE OF DEATH
a. COUNTY: Kent County, aryland MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R.F.D. [illegible] town, d.
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): at the home of her Daughter

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland, b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R.F.D. Chestertown, aryland
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Minnie Middle: B. Last: Grinnell
4. DATE OF DEATH: Month: 5 Day: 1 Year: 19 67
5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1/3/1886
9. AGE (In years last birthday): 81 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor
10b. KIND OF BUSINESS OR INDUSTRY: Various
11. BIRTHPLACE (County & State, or foreign country): Kent County, Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Randell Jackson
14. MOTHER'S MAIDEN NAME: Violet Grayson
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO: 215-36-1147
17. INFORMANT: Mrs. Ruth Thompson Address: R.F.D. Box 71 Chestertown, d.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebro-Vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 4 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arterio Sclerosis
DUE TO (c): Old age
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6-6-, 1963, to 4-28, 1967, that (I) (we) last saw the deceased alive on 4-28 1967, and that death occurred at 10 PM, from the causes and on the date stated above.

22a. SIGNATURE: Rudolfs Egļītis M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED: 5-3-67
22c. PHYSICIAN'S NAME (Type): Rudolfs Egļītis M.D.
22d. ADDRESS: Rock Hall, aryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/6/1967
23c. NAME OF CEMETERY OR CREMATORY: Asbury Methodist Cem.
23d. LOCATION (City, town or county) (State): R.F.D. Chestertown, d.
24. FUNERAL DIRECTOR: Kenneth Wadey ADDRESS: Chestertown, Md.
25a. REC'D BY REGISTRAR: MAY 9 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06785 — 06773

FOR STATE HEALTH DEPT

1 PLACE OF DEATH
a COUNTY: Kent
b CITY OR TOWN (Name): Rural Chestertown
c LENGTH OF TIME IN THIS PLACE: lifetime
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Quaker Neck Section

USUAL RESIDENCE (Where deceased lived)
a STATE: Maryland
b COUNTY: Kent
c CITY OR TOWN (Name): Rural Chestertown
d STREET ADDRESS: Quaker Neck Sec.
e IS RESIDENCE ON A FARM? xx

3 NAME OF DECEASED (First, Middle, Last): Robert J. Hickman Jr.
4 DATE OF DEATH: May 22, 1967
5 SEX: male
6 COLOR OR RACE: white
7 MARRIED xx NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 3/9/27
9 AGE (Last birthday) years: 40
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HR: Hours / Minutes
10 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Laborer
11 KIND OF BUSINESS OR INDUSTRY:
12 BIRTHPLACE (State or foreign country): Kent Co. Maryland
CITIZEN OF WHAT COUNTRY? USA
13 FATHER'S NAME: Robert J. Hickman
14 MOTHER'S MAIDEN NAME: Miriam Keeley
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no
16 SOCIAL SECURITY NO: 221 14 7315
17 INFORMANT (Address): Eleanor F. Hickman Chestertown, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: short
DUE TO
(b): Suicide by hanging.
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO TERMINAL DISEASE CONDITION GIVEN IN PART I
AUTOPSY? YES ☐ NO ☒

19 WAS OPERATION PERFORMED FOR ANY CONDITION IN PART I OR II DURING PAST YEAR? YES ☐ NO ☒
20a FATAL IF NOT PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury. Fracture of skull, not skull fracture): Self inflicted
20c TIME OF INJURY Month, Day, Year: 5/22 1967
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): house
(City or Town) Chestertown (County) Kent

21 I certify that I took charge of the remains described above held an Autopsy ☐ Inspection ☒ Inquiry ☐, and in my opinion death resulted from Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Robert W. Earr
EXAMINER'S NAME (Type): Robert W. Earr
Address (Street, city, town, or county): Chestertown Kent Co. Md.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22 DATE SIGNED: 5/23/67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 5/25/67
23c NAME OF CEMETERY OR CREMATORY: Chester Cem.
23d LOCATION (City or Town) (County) (State): Chestertown, Md.
24 FUNERAL DIRECTOR: J. Willis Wells
ADDRESS: Chestertown, Md.
25 DATE RECEIVED BY REGISTRAR: MAY 26 1967
26 REGISTRAR: Thomas Judge

THE DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to [illegible] 5 may be retained for your files. TO FUNERAL DIRECTOR: [illegible] as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

36786

06774

1

1 PLACE OF DEATH
a COUNTY: Kent
MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): RURAL Rock Hall
c LENGTH OF STAY In Ib: 12 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Skinner's Neck

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Maryland
b COUNTY: Kent
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): RURAL Rock Hall
d STREET ADDRESS: Skinner's Neck
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First SARAH Middle VIRGINIA Last JONES
4 DATE OF DEATH: Month MAY Day 14 Year 1967
5 SEX: FEMALE
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: APR. 16, 1875
9 AGE (In years last birthday): 92 yrs
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS Hours / Min
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired): HOME
10b KIND OF BUSINESS OR INDUSTRY: HOME
11 BIRTHPLACE (County & State or foreign country): CENTREVILLE, QUEEN ANNE'S CO., MD.
12 CITIZEN OF WHAT COUNTRY: U.S.A.
13 FATHER'S NAME: GEORGE WASHINGTON HARRIS
14 MOTHER'S MAIDEN NAME: SARAH V. R.N.A. SAULSBURY
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16 SOCIAL SECURITY NO: 218-20-3215
17 INFORMANT: William Jones, Address: Rock Hall, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary Thrombosis
DUE TO (b): Hypertension
DUE TO (c): Cardio Vascular Disturbance
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year, Hour o.m. p.m., 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg. etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept 28, 1953, to May 14, 1967, that (I) (we) last saw the deceased alive on May 12, 1967, and that death occurred at 5.45 P.M., from causes and on the date stated above

22a. SIGNATURE: Norbert C. Nitsch, M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED
22c PHYSICIAN'S NAME (Type): NORBERT-C NITSCH
22d ADDRESS: ROCK-HALL-MD

23a BURIAL, CREMATION REMOVAL (Specify): Burial
23b. DATE THEREOF: May 17, 1967
23c. NAME OF CEMETERY OR CREMATORY: Crosstrees Cemetery
23d LOCATION (City or Town) (County) (State): Centreville, Queen Anne's Co., Md.
24 FUNERAL DIRECTOR: Frank W. Batton Jr. ADDRESS: Batton Bros., Centreville, Md.
25a RECD BY REGISTRAR DATE: MAY 18 1967
25b REGISTRAR'S SIGNATURE: Emily Sudge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

96787 — 06775

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Worton
c. LENGTH OF STAY IN 1b: 40 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Little Comm

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Worton
d. STREET ADDRESS: Little Comm
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: A. — Last: Loud

4. DATE OF DEATH: Month: May — Day: 29 — Year: 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 23 1891

9. AGE (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chairman

10b. KIND OF BUSINESS OR INDUSTRY: Farm & feed

11. BIRTHPLACE (County & State, or foreign country): Fowlers Kent Co. Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Loud

14. MOTHER'S MAIDEN NAME: Rachel Maskin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 216-09-6022

17. INFORMANT: Mrs Ethel R Loud — Address: Worton Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Short

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic cardiovascular disease — several years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/26, 1961, to 5/29, 1967, that (I) (we) last saw the deceased alive on 5/29 1967, and that death occurred at 4:30 A M, from the causes and on the date stated above.

22a. SIGNATURE: Robert W Farr — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: ~~5/30~~ 6/1/67

22c. PHYSICIAN'S NAME (Type): Robert W. Farr, M. D.

22d. ADDRESS: Chestertown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 1 1967

23c. NAME OF CEMETERY OR CREMATORY: Christ Cemetery

23d. LOCATION (City, town or county) (State): Chestertown Kent Co. Md.

24. FUNERAL DIRECTOR: William C. Williams — ADDRESS: Chestertown Md

25a. REC'D BY REGISTRAR DATE: JUN 5 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06785 — 06776

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Kent — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Chestertown
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): ~~107 High St.~~ Kent & Queen Anne

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Kent
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
   d. STREET ADDRESS: 107 High St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jesse — Middle: W. — Last: Moffett
4. DATE OF DEATH: Month: May — Day: 23, — Year: 1967
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Mar. 9, 1901
9. AGE (In years last birthday): 66 yrs.
   IF UNDER 1 YEAR — Months: — Days: — IF UNDER 24 HRS. — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Schoolteacher
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Kent CO. Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Pearly Moffett
14. MOTHER'S MAIDEN NAME: Sarah Pennington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 207 16 3007
17. INFORMANT: Margaret S. Moffett — Address: Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2½ hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic cardiovascular disease — several years
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/5/66, 19__, to 5/23, 1967, that (I) (we) last saw the deceased alive on 5/23/ 1967, and that death occurred at 2 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Robert W. Farr — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/23/67
22c. PHYSICIAN'S NAME (Type): Robert W. Farr
22d. ADDRESS: Chestertown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/25/67
23c. NAME OF CEMETERY OR CREMATORY: Old Bohemia Cem.
23d. LOCATION (City, town or county) (State): Warick, Md.

24. FUNERAL DIRECTOR: J. Willis Wells — ADDRESS: Chestertown, Md.
25a. REC'D BY REGISTRAR DATE: MAY 29 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

96783

CERTIFICATE OF DEATH

06777

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: Kent	MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown	c. LENGTH OF STAY IN 1b: 34 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Kent & Queen Anne's Hospital	
2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: Maryland	b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ////////// Betterton Still Pond	
d. STREET ADDRESS: None	e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Grace	Gertrude	Rasin	5	29	1967

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min.
Female	White	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	1/8/1887	80 yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	HOME	Maryland	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas F. Rasin	Alice Jewell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	Address
No	—		Hospital Records	Chestertown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): CARCINOMATOSIS — INTERVAL BETWEEN ONSET AND DEATH: Few days

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b): CARCINOMA OF L.T. BREAST operated — 4 years

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ~~5x~~ 4/25, 1967, to 5/29, 1967, that (I) (we) last saw the deceased alive on 5/29 1967, and that death occurred at 1:30 P.M., from causes and on the date stated above.

22a. SIGNATURE	ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐	22b. DATE SIGNED
Dr. Jorge Oteiza M.D.		5/29/67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Dr. Jorge Oteiza	Chestertown, Maryland

23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6-1-67	St. Paul's Cemetery	Still Pond Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Nesbitt Funeral Home	Still Pond Md	JUN 1 1967	

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06790

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06778

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Worton
c. LENGTH OF STAY IN 1b: 30 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Annes Emergency Room

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Worton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dorothy — Middle: Lyle — Last: Schnoor

4. DATE OF DEATH: Month: May — Day: 8 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: Sep 22 1903

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HouseKeeper & Avon

10b. KIND OF BUSINESS OR INDUSTRY: Saleswoman

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Maxwell Byrd

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 220 14 4843

17. INFORMANT — Address: Otto SCHNOOR , Worton, Md. (husband)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ~~Arteriosclerotic Cardiovascular Disease~~ — INTERVAL BETWEEN ONSET AND DEATH: 1 month
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Had an attack while sitting in a chair, and slumped over unconscious. Just before, had complained of indigestion
DUE TO
(c) Manner of death resembled cardiac arrest. Time- 11:30 PM

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH:

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Robert W. Farr M.D.

EXAMINER'S NAME (Type): Robert W. Farr

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): Kent County

22. DATE SIGNED: 5/9/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/11/67

23c. NAME OF CEMETERY OR CREMATORY: Chester Cem.

23d. LOCATION (City or Town) (County) (State): Chestertown, Md.

24. FUNERAL DIRECTOR: J. Willis Wells — ADDRESS: Chestertown, Md.

25a. FILED BY REGISTRAR — DATE: MAY 12 1967

25b. REGISTRAR'S SIGNATURE: Jeanne Judge

VR A15ME (5)
6M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06731

CERTIFICATE OF DEATH

06779

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Chestertown,
c. LENGTH OF STAY IN 1b: 20 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): High St.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
d. STREET ADDRESS: 541 High St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Homer — Middle B. — Last Simpkins

4. DATE OF DEATH: Month May — Day 30 — Year 19 67

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 1/2/1887

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Iron worker and builder(ret)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: David Simpkins

14. MOTHER'S MAIDEN NAME: Elmira Baxter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 220 26 2772

17. INFORMANT: Mrs. Esther Dean, Address 15 S. Morton Ave, Morton, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Complications of old age
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 26, 1962 to 5-30, 1967, that (I) (we) last saw the deceased alive on 5-25 1967, and that death occurred at 8 P.M. from the causes and on the date stated above.

22a. SIGNATURE: A. C. Dick M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/30/67

22c. PHYSICIAN'S NAME (Type): A. C. Dick

22d. ADDRESS: Chestertown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/3/67

23c. NAME OF CEMETERY OR CREMATORY: St. Paul Cemetery

23d. LOCATION (City, town or county) (State): near Chestertown, Md.

24. FUNERAL DIRECTOR: J. Willis Wells

ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE: JUN 2 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65